

PATIENT NAME _____ DATE _____
LAST FIRST M

Primary reason for this dental appointment : _____

DENTAL HISTORY

PLEASE CIRCLE

Do you have a specific dental problem? Describe : _____ YES NO
Do you have a dental examination on a routine basis? Last visit : _____ YES NO
Would you describe your present dental health as good? Comments : _____ YES NO
Do you think you have active decay or gum disease? _____ YES NO
Do your gums ever bleed? Discuss : _____ YES NO
Do you brush and floss on a routine basis? Discuss : _____ YES NO
Are you aware of clenching or grinding your teeth? _____ YES NO
Is any part of your mouth sensitive to hot /cold or biting/chewing? _____ YES NO
Do you feel nervous about having dental treatment? _____ YES NO
Have you ever had a bad experience in a dental office? Describe : _____ YES NO
Do you want to keep your remaining teeth? _____ YES NO
Do you like your smile? Why? _____ YES NO
Name of previous dentist _____
Who referred you to our office? _____

MEDICAL HISTORY

(Confidential. Repeated every five years.)

Height : _____ Weight : _____ Current Age : _____ Birth Date : _____
Medical doctor's name: _____ Date of last physical exam : _____

(Women) Are you pregnant? Yes No Expected delivery date: _____

Are you under a doctor's care now? Yes No If so, for what reason? _____

Are you taking any medications, pills or drugs? Yes No Please list : _____

Have you ever been advised **not** to take any medications? Yes No What med? _____ Why? _____

Have you been advised to take a pre med before dental treatment? Yes No If yes, for what? _____
What med? _____

Have you ever had any of the following? Indicate YES with check mark ()

- Any heart problems
- High blood pressure
- Low blood pressure
- Circulatory problems
- Excessive bleeding
- Anemia
- Rheumatic fever
- Use of tobacco
- Headaches
- Glaucoma or Cataracts
- Scarlet fever
- Kidney disease
- Nervous problems
- Psychiatric care
- Hospitalization
- Thyroid problems
- Diabetes
- Arthritis
- Malignancies
- Radiation treatments
- Asthma
- Stroke
- Ulcer
- Frequent indigestion
- Hepatitis
- Aids / HIV Positive
- Venereal Disease
- Herpes
- Tuberculosis
- Sinus problems
- Tonsillitis
- Prosthetic valves/joints
- Allergy to anesthetics:
- Allergy to medications/drugs:
- Other allergies:

Have you ever had any other serious illness? Yes No Explain: _____

Have you been hospitalized in the last two years? Yes No Why? _____

Have you ever had difficulty with anesthetics? Yes No Explain: _____

Do you have any disease, condition or problem not listed above? Yes No Explain: _____

Have you ever had any cosmetic procedure? Yes No If yes, please explain _____

Do you wish to talk to the doctor about any problem not listed? Yes No Comments: _____

AUTHORIZATION: I hereby authorize the doctors and/or staff of the Dental Cosmetic Center to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge. I will notify the doctor of any changes in my health or medication.

Patient Signature : _____ Date : _____

Reviewed by Doctor : _____ Date : _____ B/P _____

MEDICAL UPDATES

Notes :